

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		c. LENGTH OF STAY IN 1b 31-Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS 13-Glymont Road, Indian Head Md,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Russell Meredith Bowie		First	Middle	Last	4. DATE OF DEATH 11-29-59	Month	Day	Year 19
5. SEX Male		6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-28	9. AGE (In years for birthday) 31-Yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY Naval Propellant Plant, Indian Head Md.		11. BIRTHPLACE (State or foreign country) Pisgah Md.		12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME James Russell Bowie		14. MOTHER'S MAIDEN NAME Mary Elizabeth Abel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-2888		17. INFORMANT Mother—Mrs Mary Elizabeth Wood		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pisgah	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE James E. Andrews MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
DATE SIGNED 12-1-59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-3-59	22c. NAME OF CEMETERY OR CREMATORIAL Nazarene	22d. LOCATION (City, town, or county) Pisgah, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS	24a. REC'D BY REGISTRAR DEC 4 '59	24b. REGISTRAR'S SIGNATURE Clyde S. Kraus				

STATE OF
TEXAS

DEPARTMENT OF STATE - DIVISION OF
ELECTIONS - STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12496

CERTIFICATE OF DEATH

Reg. Dist. No.

12484

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bryantown,		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Samuel	Middle Adams	Last Farmer	4. DATE OF DEATH November 5 1959	Month November	Day 5	Year 1959
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1882		9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Francis Farmer		14. MOTHER'S MAIDEN NAME Rose Jackson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT George Farmer, Aquasco, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) - (c)		Old age & Senility.				INTERVAL BETWEEN ONSET AND DEATH years.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stomach Tumble						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) years						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) Aquasco	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from <u>May 4</u> , 1959, to <u>Oct 1</u> , 1959, that I last saw the deceased alive on <u>Oct 26</u> , 1959, and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Vahéh M. Seron</u> M.D. ADDRESS (Street, city or town, state) <u>Aquasco, Md 11/6/59</u> DATE SIGNED <u>11/6/59</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-59	22c. NAME OF CEMETERY OR CREMATORIAL St. Marys		22d. LOCATION (City, town, or county) Bryantown, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 12 '59		24b. REGISTRAR'S SIGNATURE G. James S. Krause		

STATE OF MARYLAND
DEPARTMENT OF HEALTH-
CERTIFICATE OF DEATH

25

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12497

CERTIFICATE OF DEATH

12485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 16		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edwin Hiram Franklin		First Edwin		Middle Hiram		Last Franklin		4. DATE OF DEATH November 24 1959	Month 19	Day 19	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20 1885		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY US Governemt		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Smith Franklin				14. MOTHER'S MAIDEN NAME Mary (last name unknown)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Davis Franklin, La Plata, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO		Arteriosclerotic Heart Disease		5yrs.					
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from May 12, 1959, to Nov. 24, 1959, that I last saw the deceased alive on Nov 24, 1959, and that death occurred at 2:30 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Frank G. Person M.D.						ADDRESS (Street, city or town, state)		DATE SIGNED			
PHYSICIAN'S NAME (Type) Frank Susan M.D.				Indian Head, Md.							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) burial		22b. DATE THEREOF Nov. 27 1959		22c. NAME OF CEMETERY OR CREMATORIUM Chicamuxen M.E.		22d. LOCATION (City, town, or county) Chicamuxen, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE Suzanne E. [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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570

152 *Journal of Health Politics*

4

ANSWER

W. E. L.

1
FOR STATE
HEALTH DEPT.

Items 18 & 21 Film 252
11-19-59 a.m.s

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1959

12453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12486

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) THOMAS		First	Middle	Last	4. DATE OF DEATH November 5, 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1918	9. AGE (In years lost birthday) 41 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas F. Goldsmith		14. MOTHER'S MAIDEN NAME Lucy Goldsmith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wilfred Goldsmith - Bel Alton, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 882.9		DUE TO Ethylene glycol poisoning				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Undetermined manner						
20c. TIME OF INJURY Hour a.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bel Alton		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE		William V. Lovitt, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/6/59		
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/1959		22c. NAME OF CEMETERY OR CREMATORIAL St. Ignatius Cemetery		22d. LOCATION (City, town, or country) Bel Alton, Md.		(State)
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur & Francis		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12487

12499

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Charles</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf, Rural</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf, Rural</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary Louvenia</i>		First	Middle	Last	4. DATE OF DEATH <i>Nov. 11</i>	Month	Day	Year <i>1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4 1886</i>		9. AGE (in years lost birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Frank Edelon</i>		14. MOTHER'S MAIDEN NAME <i>Mary Louvenia Edelon</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>None McKinley Greenfield, Waldorf Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Cardiologic Renal Failure</i> (c) <i>Hodgkin's Disease</i>		
19. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>		
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Aug 17</i> , 1959, to <i>Nov 11</i> , 1959, that I last saw the deceased alive on <i>Nov 11</i> , 1959, and that death occurred at <i>10:45 P.M.</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>J. M. Seron MD</i>		M.D.		ADDRESS (Street, city or town, state) <i>Agnew, Md</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 14, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Peter's</i>		22d. LOCATION (City, town, or county) (State) <i>Waldorf, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home, Waldorf, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>John & Kline</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Wm. W. Madsen

12-13-1891 Wm. W. Madsen
Wm. W. Madsen

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12500

CERTIFICATE OF DEATH

12488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>		d. STREET ADDRESS <i>12500</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY C</i>		First	Middle	4. DATE OF DEATH <i>HANCOCK</i>	Month	Day	Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 25 1863</i>	9. AGE (in years last birthday) yrs. <i>96</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Thompson</i>		14. MOTHER'S MARRIED NAME <i>Jane Hancock</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i></i>	
17. INFORMANT <i>Thomas Hancock</i>		18. ADDRESS <i>Hughesville Md</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <i>1956</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>160.0</i>		DUE TO <i>Cancer of Nose</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) DUE TO <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1956</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>			
21. I certify that I attended the deceased from <i>1956</i> , 19, to <i>11-1</i> , 19, that I last saw the deceased alive on <i>10-25-59</i> , and that death occurred at <i>Hughesville</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. J. Edelen</i>		M.D.		ADDRESS (Street, city or town, state) <i></i>		DATE SIGNED <i>Dec 10 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-3-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Old Fields Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hughesville, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Honolulu Funeral Home, Waldorf, Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>NOV 3 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. French</i>	

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TO HOSPITAL OR PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12501

CERTIFICATE OF DEATH

Reg. Dist. No.

12489

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>		b. COUNTY <i>Charles</i>	
c. LENGTH OF STAY IN b. <i>Hughesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>J</i>	Middle <i>F.</i>
4. DATE OF DEATH <i>Nov. 9 1959</i>	Month <i>Nov.</i>	Day <i>9</i>	Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 6 1914</i>
9. AGE (In years last birthday) <i>44</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NON-WORKING</i>	11. KIND OF BUSINESS OR INDUSTRY <i>—</i>	12. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
13. FATHER'S NAME <i>Joseph H. Jenkins</i>	14. MOTHER'S MAIDEN NAME <i>Irene Jones</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	17. SOCIAL SECURITY NO. <i>213-12-4702</i>	18. INFORMANT <i>Mrs. John H. Farwell</i>	Address <i>Hughesville, Md.</i>
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>141.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>	
DUE TO <i>CARCINOMA, POSTERIOR TONGUE</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>—</i>		DUE TO <i>CEREBRAL EMBOLISM</i>	
DUE TO <i>CEREBRAL PALSY</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>	
(County) <i>—</i>		(State) <i>—</i>	
21. I certify that I attended the deceased from <i>September 1959</i> to <i>November 9, 1959</i> , that I last saw the deceased alive on <i>November 9, 1959</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>—</i>	
ACTUAL SIGNATURE <i>John H. Griffin, M.D.</i>		DATE SIGNED <i>11/09/59</i>	
PHYSICIAN'S NAME (Type) <i>John H. Griffin, M.D.</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>11-11-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Olivet</i>	
22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 13 '59</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>C. Hunt & Sons</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12502

CERTIFICATE OF DEATH

12490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		d. STREET ADDRESS 1203 Raymond Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital LaPlata				d. STREET ADDRESS 1203 Raymond Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Edward	Middle Bayard	Last Land	4. DATE OF DEATH November 5	Month November	Day 5	Year 1959	
S. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 25 1886	9. AGE (In years less birthday) 73 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward B. Land				14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT N. R. Cary, Indian Head, Md.		Address		
no		none						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio Sclerosis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 2-4 hours								
Indefinite								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Patient had Ringers Disease for which one leg was amputated in 1957								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from 10-19-59, 19-11-5-59, 19, that I last saw the deceased alive on 11-5-59, 19, and that death occurred at 4:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Indian Head, Md.								DATE SIGNED 11-6-59
ACTUAL SIGNATURE 								
PHYSICIAN'S NAME (Type) James E. Andrews M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORIAL Pine Mountain Cem		22d. LOCATION (City, town, or county) Pine Mountain, La		
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE NOV 10 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus		

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12491

12503

Item 14 11mg22 11-23-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN lb /			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			
3. NAME OF DECEASED (Type or print) Robert L. Payne		4. DATE OF DEATH November 14 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 28 1882	9. AGE (In years last birthday) 77 yr.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Payne		14. MOTHER'S MAIDEN NAME Hattie (Maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ex. no. or unknown) no		16. SOCIAL SECURITY NO. 220 26 4959	17. INFORMANT Robert Payne, Waldorf, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Collapsed while stripping tobacco			
20c. TIME OF INJURY Hour o. m. 9.30 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	20f. (City or town) Waldorf, Charles, Maryland	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE J. B. Dettor		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-14-59	
EXAMINER'S NAME (Type) V. B. Dettor, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-17-59	22c. NAME OF CEMETERY OR CREMATORIUM Clifton	22d. LOCATION (City, town, or county) Clifton, Va.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home,		ADDRESS Waldorf, Md.	24a. REC'D BY REGISTRAR NOV 19 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

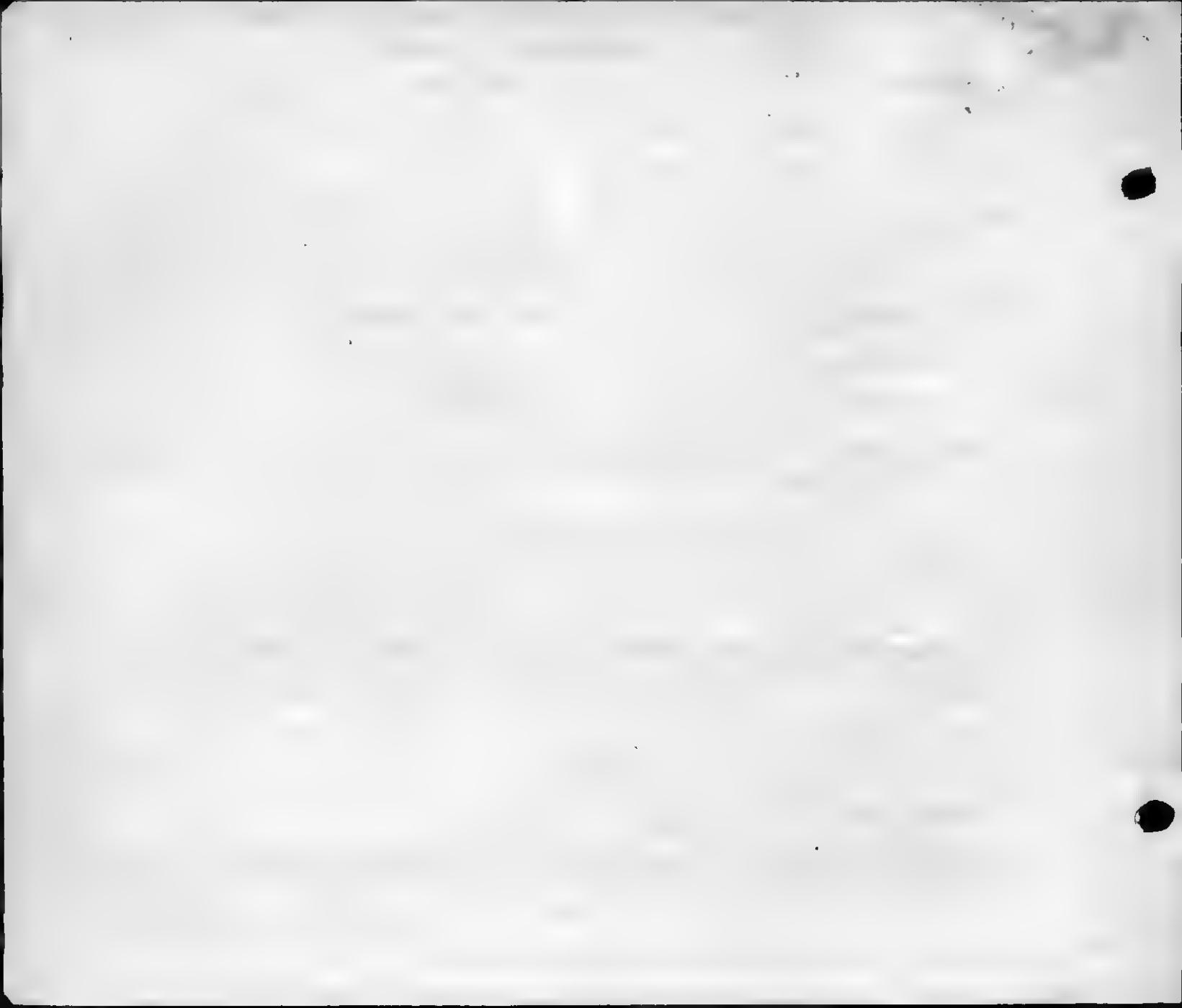
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12504

CERTIFICATE OF DEATH

12492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf Md		c. LENGTH OF STAY IN 1b 3-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf-Rural Md		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora Cecelia Serrin		First	Middle	Lost	4. DATE OF DEATH 11-2-59	Month	Day	Year 19	
5. SEX Female	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-13-03	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Drug Distributer		11. BIRTHPLACE (State or foreign country) Washington-D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas H. Serrin		14. MOTHER'S MAIDEN NAME Sara A. Brown BOWERS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. Hilda Scott-Sister		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 2-YRS.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Left Breast</u> 170X		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <u>Metastasis Chest and Left Arm</u>				2-Yrs			
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>3-11th</u> <u>7-15-59</u> <u>11-2-59</u> , 19____, that I last saw the deceased alive on <u>11-2-59</u> <u>19</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>Indian Head Md</u>									
ACTUAL SIGNATURE <u>James H. Andrews</u>								DATE SIGNED <u>11-2-59</u>	
PHYSICIAN'S NAME (Type) <u>James H. Andrews MD</u>									
22a. BURIAL/CREMAT. ON. <u>burial</u> <u>11-5-59</u>		22b. DATE THEREOF <u>11-5-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill</u>		22d. LOCATION (City, town, or locality) <u>Seaboard Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc. 517 11th St. S.E.</u>		ADDRESS <u>vs A15 (4) 15M 9/55</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Parsons</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

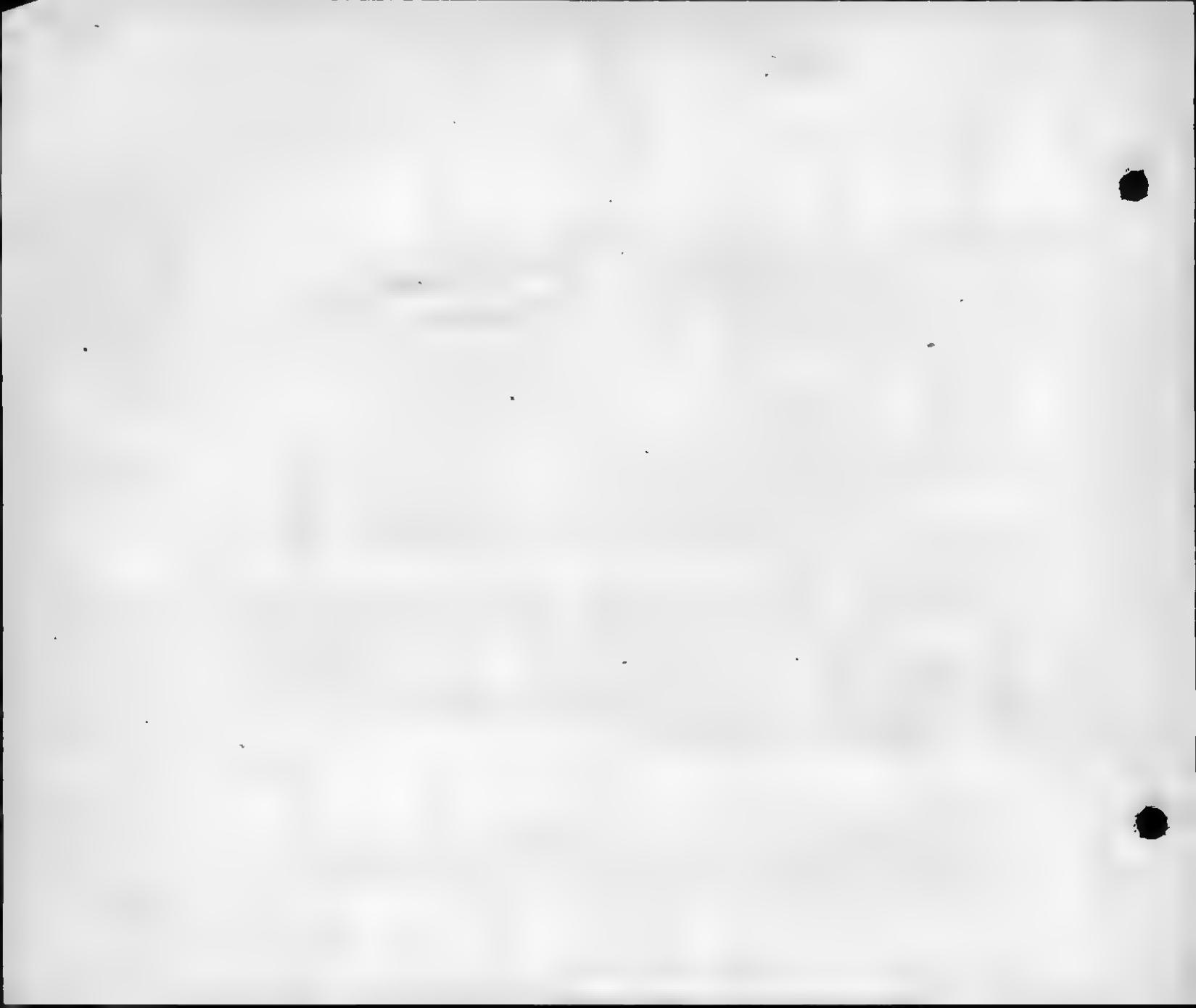
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12493

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b SINCE 9-20-59	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest A. Stewart		4. DATE OF DEATH Month 11 Day 2 Year 1959	
5. SEX Male COLOR OR RACE Negro		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4 August 11, 1911 9. AGE (In years last birthday) 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Stewart		14. MOTHER'S MAIDEN NAME Mary Sophia Nelson Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-16-2516 17. INFORMANT Mrs. Ruth Stewart, Bryantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 10-31-59 Multiple fractures of spine 9-20-59	
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9-20-59	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car auto accident	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9-20 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Charles, Md. (County) Charles Co. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. Edelein		DATE SIGNED 11-4-59	
EXAMINER'S NAME (Type) E. J. Edelein		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-59	
22c. NAME OF CEMETERY OR CREMATORIAL St Marys		22d. LOCATION (City, town, or county) Bryantown, Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Shurtliff Funeral Home, Waldorf, Md.		ADDRESS	
24a. REC'D BY REGISTRAR NOV 10 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	
VS. AT SME(S) 5M 9/55			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12506

CERTIFICATE OF DEATH

Reg. Dist. No.

12494

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		d. STREET ADDRESS <i>Waldorf</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION							
3. NAME OF DECEASED (Type or print)	First <i>Emmanuel</i>	Middle 	Last <i>Thompson</i>	4. DATE OF DEATH Month <i>November</i>	Day <i>7</i>	Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 13, 1878</i>	9. AGE (In years last birthday) yrs <i>81</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John R. Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Savoy</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Katie Proctor, 84122 Brandywine, Md.</i>		Address <i>Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Arteriosclerosis -</i>							
DUE TO (b) <i>Heart Disease</i>							
DUE TO (c) <i>From Fall</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Intertrochanteric Fracture - Femur - operated</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell off Porch at Home</i>		20c. TIME OF INJURY 8:30 a.m. 10/18/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 19	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>RR - Waldorf, Charles</i>		(County) <i>Charles</i>		(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>Oct 19, 1959</i> to <i>Nov 7, 1959</i> that I last saw the deceased alive on <i>Nov. 7, 1959</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>V.M. SERON MD.</i>				ADDRESS (Street, city or town, state) <i>Openwood Rd</i>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <i>11/10/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-11-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's</i>		22d. LOCATION (City, town, or county) <i>Newport, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		ADDRESS <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. Sims & Sons</i>	

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12.11 Budgeted general revenue consists of 162 contributions, 100% of which are general contributions.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG253 12-7-59 et

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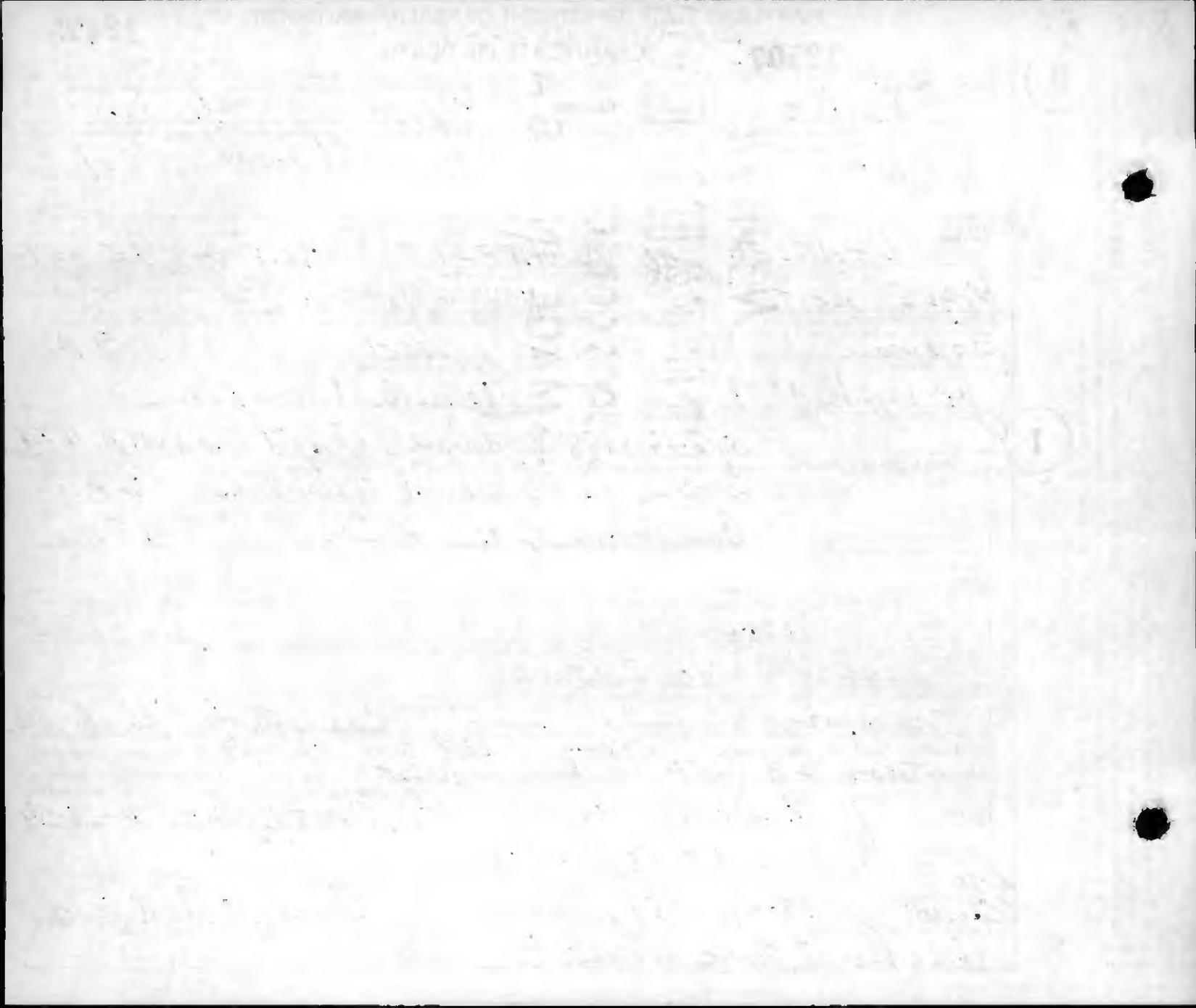
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newport</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>	
3. NAME OF DECEASED (Type or print) CHARLES		First W	Middle E
4. DATE OF DEATH NOVEMBER 25 1959		Month NOV	Day 25
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 4 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Co</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Joseph P Tippett</i>	14. MOTHER'S MAIDEN NAME <i>Renata Thompson</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>	16. SOCIAL SECURITY NO. <i>378-18-8688</i>	INFORMANT <i>Modeline Tippett</i>	Address <i>Charlotte Hall, Charles, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Abdominal Metastases</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of the Liver</i>		15 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>No injury</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No INJURY</i>	
20c. TIME OF INJURY Month, Day, Year <i>Nov. 23 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
21. I certify that I attended the deceased from <i>May</i> , 1959, to <i>Nov. 25</i> , 1959, that I last saw the deceased alive on <i>Nov. 23</i> , 1959, and that death occurred at <i>10:35PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	
ACTUAL SIGNATURE <i>V. B. Dettor, M.D.</i>		DATE SIGNED <i>11-26-59</i>	
PHYSICIAN'S NAME (Type) <i>V. B. DETTOR, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>11-28-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Marys</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Lee La Plata</i>		24a. REC'D BY REGISTRAR <i>DEC 3 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12496

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury		c. LENGTH OF STAY IN 1b 45-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Marbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Willie		First Willie	Middle Cyrus	Last Wheeler	4. DATE OF DEATH 11-3-59	Month 11	Day 3	Year 1959
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-82	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building Trade		11. BIRTHPLACE (State or foreign country) Doncaster MD.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Peter L. Wheeler				14. MOTHER'S MAIDEN NAME Roberta Gertrude Kilstead				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Leslie Dean-(Son-in-Law)		Address Marbury Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Acute Coronary Occlusion DUE TO (c) Arterio Sclerosis General						INTERVAL BETWEEN ONSET AND DEATH 3-Yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Indian Head Md.	(County) Calvert Co.	(State) Md.	
21. I certify that I attended the deceased from 11-3-59, 19, to 11-3-59, 19, that I last saw the deceased alive on 11-3-59, and that death occurred at 4:05 PM M, from the causes and on the date stated above. ACTUAL SIGNATURE James E. Andrews PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state) Indian Head Md. DATE SIGNED 11-5-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/6/59	22c. NAME OF CEMETERY OR CREMATORIAL Chicamuxen M. E. Cemetery, Chicamuxen, Maryland		22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. - In Plaza, Md.		ADDRESS Archart Funeral Home, Inc. - In Plaza, Md.	24a. REC'D BY REGISTRAR DATE NOV 9 '59	24b. REGISTRAR'S SIGNATURE C. Archart				

WILLIAMS STATE GOVERNMENT OF HAWAII-TERRITORY, 18

CERTIFICATE OF DEATH

1898

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